DDSN PROTOCOL FOR CONDUCTING ICF/MR UTILIZATION REVIEWS

Effective August 2003

In order for a DDSN eligible consumer to claim Medicaid reimbursement for Intermediate Care Facility (ICF/MR) services, Title XIX of the Social Security Act requires that a Utilization Review (UR) be conducted as stipulated within 42 Code of Federal Regulation, Chapter IV; Subpart F; § 456.401 through § 456.438.

The purpose of the UR is to validate the consumer's Level of Care determination to ensure that ICF/MR services are necessary, and that services are of a quality and cost to meet professionally recognized standards of health care. The UR should be conducted using the sequential steps below:

Definitions:

- "Provider" = Regional or community based ICF/MR.

- "Designee" = A professional with a Bachelors degree in human services from an accredited college or university as identified by the Provider's policy, or nurse.

STEP # 1

The Provider's Director of Nursing (or designee) is responsible for ensuring that the UR is conducted:

A. Within six months after the initial Level of Care determination is made;

B. Within six months after the initial UR; and

C. Within every six months thereafter.

The UR Committee must be comprised of

A. At least one physician who serves as chairperson for the committee, and

B. At least one other person knowledgeable in the treatment of mental retardation or related disabilities.

The UR Committee should not include individuals who are directly responsible for the care of the consumer whose care is being reviewed; are employed by the ICF/MR; or has a financial interest in any ICF/MR.

STEP # 2

The Provider's Director of Nursing (or designee), in conjunction with the consumer's QMRP, is responsible for making sure the following support documents are made available to the UR Committee as a basis for their determination:

1. Formal psychological evaluation(s) that includes cognitive and adaptive scores (does not have to be current within three (3) years). Every effort should be made to locate actual evaluation report(s) vs. referencing results noted on another document. If report(s) cannot be located, the following other sources may be used:

    - DDSN Eligibility Letter;
    - DDSN STS Eligibility Menu
    - Any other document which includes test used, scores, and date

    If the consumer does not have mental retardation and/or is served in another eligibility category (i.e. related disability), appropriate supportive documentation is required. This may not be a psychological evaluation, but may be e.g. a report from the DDSN Autism Division (ex. Related Disability).

2. Current Single Plan, or Individualized Family Service Plan.

3. Any/all other current (within one year) information pertaining to:

    - Daily living and other adaptive functioning
    - Behavioral/emotional functioning; and/or
    - Medical and related health needs

STEP # 3

Based on support documents noted in Step #2, the UR Committee is responsible conducting an on-site review to:

A. Validate that a physician (based on support documentation noted in Step #2) makes the consumer's Level of Care determination.

B. Validate that services are necessary and of quality and cost to meet professionally recognized standards of health care (e.g., based on each consumer's assessed needs).

STEP # 4

The UR Committee should document their findings on the UR Minutes form (Attachment A), which is maintained in the consumer's record.

Adverse Decisions Regarding LOC:

When the UR Committee recommends that continued stay is not justified, the UR committee must notify the consumer's primary care physician and qualified mental retardation professional within one (1) business day of the decision. Subsequently, consumer's primary physician and qualified mental retardation professional are allowed two (2) business days from the notification date to present their views before the UR committee makes a final decision on the need for the continued stay.

When the consumer's primary care physician and/or qualified mental retardation professional do not present additional information or clarification of the need for the continued stay, the decision of the UR committee is final.

When the consumer's primary care physician and/or qualified mental retardation professional present additional information or clarification, the need for continued stay is reviewed by the physician member(s) of the UR Committee, in cases involving a medical determination; or, the UR group, in cases not involving a medical determination. When the UR Committee still finds that the consumer no longer needs ICFMR services, their decision is final.

Written notice of any adverse final decision on the need for continued stay must be sent to the ICF/MR Facility or Executive Director; the consumer's primary care physician; qualified mental retardation professional; the Medicaid agency and the consumer or his/her legal representative. The notice of the adverse decision should not be later than 2 days after the date of the final decision. Subsequently, the ICF/MR Facility or Executive Director is responsible for ensuring Medicaid reimbursement for ICF/MR services is not claimed after the date of the final decision.

Negative findings associated with quality and/or cost of services:

When the UR Committee discovers negative findings associated with quality and/or cost of services, the UR committee must provide written notice to the ICF/MR Facility or Executive Director. Subsequently, the ICF/MR Facility or Executive Director is responsible for ensuring corrective action.